About Politeness, Face, and Feedback

About Politeness, Face, and Feedback: Exploring Resident and Faculty Perceptions of How Institutional Feedback Culture Influences Feedback Practices

Subha Ramani, MBBS, MMEd, MPH, Karen D. Könings, PhD, Karen V. Mann, PhD, Emily E. Pisarski, MSc, and Cees P.M. van der Vleuten, PhD

Abstract

Purpose
To explore resident and faculty perspectives on what constitutes feedback culture, their perceptions of how institutional feedback culture (including politeness concepts) might influence the quality and impact of feedback, feedback seeking, receptivity, and readiness to engage in bidirectional feedback.

Method
Using a constructivist grounded theory approach, five focus group discussions with internal medicine residents, three focus group discussions with general medicine faculty, and eight individual interviews with subspecialist faculty were conducted at Brigham and Women's Hospital between April and December 2016. Discussions and interviews were audiotaped and transcribed verbatim; concurrent data collection and analysis were performed using the constant comparative approach. Analysis was considered through the lens of politeness theory and organizational culture.

Results
Twenty-nine residents and twenty-two general medicine faculty participated in focus group discussions, and eight subspecialty faculty participated in interviews. The institutional feedback culture was described by participants as (1) a culture of politeness, in which language potentially damaging to residents' self-esteem was discouraged; and (2) a culture of excellence, in which the institution's outstanding reputation and pedigree of trainees inhibited constructive feedback. Three key themes situated within this broader cultural context were discovered: normalizing constructive feedback to promote a culture of growth, overcoming the mental block to feedback seeking, and hierarchical culture impeding bidirectional feedback.

Conclusions
An institutional feedback culture of excellence and politeness may impede honest, meaningful feedback and may impact feedback seeking, receptivity, and bidirectional feedback exchanges. It is essential to understand the institutional feedback culture before it can be successfully changed.

Feedback is most effective when it informs learners' self-assessment and influences performance.[1–5] Increasingly, the focus of feedback is shifting away from providers' feedback-giving skills toward receivers' acceptance, incorporation, and behavior change.[2,6,7] However, feedback conversations are complex interpersonal exchanges, where the lack of a shared mental model between the provider and receiver may result in defensiveness, anger, or even rejection of the information.[8–11] Sociocultural factors—including perceived threats to self-esteem and autonomy, fear of damaging relationships, skepticism about the credibility of the source, and incongruence of feedback data with self-assessments,[11–18] as well as the institutional learning culture[9,19,20]—can also impact how feedback is given and received. In a previous study, residents reported that an existing institutional culture of politeness impeded honest feedback while simultaneously enhancing the work and learning environment.[21] In this study, we aim to further explore resident and faculty perspectives on what constitutes feedback culture, their perceptions of how institutional feedback culture (including politeness concepts) might influence the quality and impact of feedback, feedback seeking, receptivity, and readiness to engage in bidirectional feedback.

Please see the end of this article for information about the authors.

Correspondence should be addressed to Subha Ramani, Internal Medicine Residency Program, Brigham and Women's Hospital, 75 Francis St., Boston, MA 02115; telephone: (617) 732-6040; e-mail: sramani@bwh.harvard.edu.

Acad Med. 2018;93:1348–1358.
First published online March 6, 2018
doi: 10.1097/ACM.0000000000002193

Supplemental digital content for this article is available at http://links.lww.com/ACADMED/A537.

Organizational Culture, Image, and Identity

Organizational culture refers to the beliefs of a community, which guide their perceptions and behavior.[22,23] Schein[22] described three levels of culture that influence organizational behavior: assumptions and beliefs that form the foundation of the culture (level 1), espoused values that underscore the organization's purpose and desired image (level 2), and visible day-to-day behavior, which is often a compromise between stated values and practical needs (level 3). Organizational culture also interacts with identity (members' feelings about their organizational mission) and image (how the organization is viewed by others) to direct community behavior.[24] In addition to an overall organizational culture, educational institutions have a learning culture, defined by Watling and colleagues[19] and Watling[20] as the shared beliefs, practices, and values that underpin how the profession designs the education of its learners. They report that medical educators tend to avoid constructive feedback and postulate that a learning culture that lacks longitudinal relationships and emphasizes learner autonomy contributes to this behavior. Thus far, only one study has reported that

medical students were willing to exchange and accept constructive feedback from peers with whom they had prior positive learning relationships.[25] How relationships with faculty could influence the quality and impact of feedback in residency education needs further inquiry.[25]

The Concept of Face and Relevance to Feedback

Goffman[26] coined the term "face" to describe how an image of oneself is constructed per approved social norms, hence professional behavior may be guided by the desire to project a positive image to others. Brown and Levinson[27] expanded on the concept of face, defining positive face as a desire for self-affirmation or self-efficacy and negative face as a desire for freedom of action or autonomy. Politeness theory, as described by Brown and Levinson,[27] assumes that most conversations can be face threatening to either the hearer or speaker and views politeness as an attempt to mitigate face-threatening acts. Language and politeness may also be influenced by social distance, power differences, and the cultural context.[27] Face has also been described as relational rather than individual, where one's sense of self develops through relationships with others.[28] Positive face, negative face, and the relational conceptualization of face are relevant to clinical settings where patient care and learning occur on teams and members of the team rely on each other to grow professionally.

Ginsburg and colleagues[29,30] invoke the politeness concept of conventional indirectness as one possible explanation for vague language used by faculty in written comments about trainee performance. They report that faculty narratives on in-training evaluation reports frequently contain vague and nonliteral language, and that other faculty often decode this language by "reading between the lines." For example, another study found that "good" may refer to underperforming trainees and "excellent" may not refer to the highest performers.[31] However, the use of nonspecific language in assessments could result in trainees misinterpreting the assessment language.[29] If learners take the comments literally, they may miss the message and preserve their self-image; if they read between the lines, they could lose face.[30] Because positive framing of feedback enhances learner satisfaction and self-efficacy,[32] feedback providers may avoid language that could threaten learners' self-esteem, while learners could reject information that threatens their self-efficacy (positive face) or autonomy (negative face).[26] The concepts of positive and negative face are also direct threats to bidirectional feedback in a hierarchical learning environment. Hidden codes, hedging, and indirectness may well be amplified during face-to-face conversations.[30] Further, feedback language may also be influenced by institutional or professional culture with conflicting implicit and explicit expectations for such conversations.[22,33]

Despite increasing knowledge about sociocultural aspects of feedback, much is still unknown about resident and faculty perspectives on what constitutes feedback culture, their perceptions of how institutional feedback culture may impact feedback, feedback seeking, receptivity, and readiness to engage in bidirectional feedback.[34–36] To better understand these, we explored the following questions:

1. How do residents and faculty define feedback culture, and what are their views regarding the impact of institutional feedback culture (including politeness concepts) on meaningful feedback?
2. What factors influence feedback seeking and receptivity, as perceived by residents and faculty?
3. What are resident and faculty perspectives regarding the value of bidirectional feedback, defined as two-way feedback from faculty to residents and residents to faculty, as well as junior to senior residents and senior to junior residents? (For the purposes of this study, the terms junior and senior refer to residents' position on a clinical team [see below].)

Insights into these issues can help medical educators design feedback initiatives that incorporate feedback seeking, receiving, and bidirectional feedback exchanges and emphasize professional growth.

Method

Using a constructivist grounded theory approach,[37–39] we conducted focus group discussions with residents, and focus group discussions and individual interviews with faculty, to explore their views on institutional feedback culture.

Setting

The internal medicine residency program in the Department of Medicine at Brigham and Women's Hospital, a teaching affiliate of Harvard Medical School, is a large urban training program consisting of approximately 160 residents across many training tracks (e.g., research, global health, primary care, management and leadership, medical education, medicine–pediatrics). Inpatient teams consist of one or two postgraduate year (PGY)-2 or PGY-3 residents (referred to as senior residents in this study), two to four PGY-1 residents (referred to as junior residents in this study), one or two attending physicians, and one or two medical students. Weekly e-mails remind residents and supervising faculty to exchange regular feedback with each other. All categorical residents (i.e., those not on a one-year preliminary track) work in continuity clinics. Residents have a longitudinal working relationship with their continuity clinic preceptor, but their working relationships with inpatient attending physicians are typically two weeks long and may be shorter depending on the block schedule. Attendings range from novice to seasoned clinicians, clinician–educators, and clinician–investigator faculty with limited teaching commitments. There is no mandate that teaching faculty receive formal feedback training, though faculty development opportunities for feedback training exist. Thus, residents receive feedback from a number of supervising faculty with variable teaching and feedback skills, with the duration and quality of these working relationships varying as well.

Framework, participants, and sampling

We believed that a constructivist grounded theory approach, which iteratively deconstructs and reconstructs meaning from participant narratives, was most appropriate to develop a theory regarding the influence of institutional culture on feedback practices.[40–42] Using a purposive sampling strategy, in April–December 2016, we invited (see below) 62 residents who had continuity clinic at the principal outpatient site for the residency program and 30 continuity clinic

preceptors who supervised residents at this site, 20 hospitalist attendings, and 12 subspecialist faculty. Faculty were selected for focus group discussions and interviews based on the fact that all of them supervise residents in clinics or on the inpatient service. Faculty who had no contact with residents were not recruited. No feedback training was offered to any of the participants. We explored their opinions and perspectives in an open-ended manner.

E-mail invitations to participate in the focus groups or interviews described the purpose of the study and emphasized that participation was voluntary, opinions were confidential, participants had the ability to opt out at any point, and all data would be deidentified. Verbal consent was obtained by S.R. prior to focus group discussions or interviews. None of the residents or faculty we contacted refused to participate, but final scheduling was based on availability on specific dates. Because we aimed to explore perspectives of residents and faculty on the institutional feedback culture and their perceptions of how it might influence the quality and impact of feedback and feedback practices, we believed that this sampling strategy would yield participants who could provide rich insights on this topic and help develop a theory.[39] Mixed groups of PGY-1, PGY-2, and PGY-3 residents were intentionally targeted to stimulate rich interactions across the different levels of residents. No incentives were offered for participation.

We conducted focus group discussions with general medicine faculty (continuity clinic preceptors and hospitalist attendings) during regularly scheduled noon faculty meetings and with residents during scheduled postclinic conferences. Focus groups are a useful strategy to study organizational culture and behavior and when enrichment of data through interactive discussions is anticipated.[43] It was not feasible to convene focus groups with subspecialist faculty, so we conducted individual interviews at times when faculty were available to meet (for sample questions, see Supplemental Digital Appendix 1 at http://links.lww.com/ACADMED/A537).[44,45]

Data collection

Five resident focus group discussions were conducted between April and June 2016. Three focus group discussions with general medicine faculty (two with continuity clinic preceptors and one with hospitalist attendings) and eight individual interviews with subspecialist faculty were conducted between September and December 2016. Data sources included transcripts from focus groups and interviews, as well as field notes and observations by a research assistant.

Using open-ended questions, we explored participant perspectives on what constitutes feedback culture, their perceptions of how institutional feedback culture (including politeness concepts) might influence the quality and impact of feedback, feedback seeking, receptivity to feedback, and bidirectional feedback. Semistructured discussions allowed us to examine participant opinions without introducing investigator assumptions and allowed us to be open to discovering unanticipated issues and opinions that differed from commonly held ones.

Focus group discussions were approximately 60 minutes, and interviews were approximately 30 minutes. The primary investigator (S.R.) led the discussions while a research assistant observed group interactions and made field notes. Trigger questions, discussed in advance by the research team, were used to initiate conversations (List 1). Responses were probed, and further open-ended questions were posed to ensure that the content of the discussions covered the study questions. Further questions were not posed if participants spontaneously covered three main areas: feedback culture, feedback seeking and receptivity, and bidirectional feedback.

Because reflexivity is essential for a constructivist approach, we reflected on the influence of researcher roles and assumptions in our approach to sampling, data collection, and analysis.[42,46] The lead author (S.R.), a faculty physician in the department, is neither a program director responsible for promotion or graduation decisions for residents nor in a position of power over fellow faculty. Her collaborators are nonphysicians and include expert health professions educators and researchers from outside institutions (C.P.M.V., K.V.M., K.D.K.). The team also included two research assistants (one observed the focus groups and took field notes, and the other participated in independent data analysis [E.E.P.]). We held postdiscussion debriefings between the observer and investigator and examined each transcript to ensure that questions were open-ended

List 1

Trigger Questions[a] for Focus Group Discussions With Residents, Continuity Clinic Preceptors,[b] and Hospitalist Attendings,[c] Internal Medicine Residency Program, Department of Medicine, Brigham and Women's Hospital, April–December 2016[d]

Feedback culture

1. When the term "feedback culture" is used, what does it mean to you?
2. How would you describe our institutional feedback culture?
3. In previous discussions, residents had expressed that our department has a culture of politeness which inhibits honest feedback conversations; what are your opinions regarding this?

Feedback seeking and receptivity

1. How important is feedback-seeking behavior in obtaining meaningful feedback?
2. What factors could increase receptivity to constructive feedback?

Bidirectional feedback

1. In your opinion, is bidirectional feedback important?
2. Can you tell us more about your thoughts on this topic?
3. What might be some strategies to stimulate bidirectional feedback?

[a]This is a sample list of focus group trigger questions and not all of the questions used. Further questions were posed based on group responses if clarifications or further elaborations were needed. Further questions were not used if participants spontaneously engaged in discussions that were related to the study questions.
[b]General internists who served as resident continuity clinic preceptors; some also attended on general medicine wards for 2 to 4 weeks a year.
[c]Attending physicians who primarily worked on general medicine wards on the teaching service.
[d]In a qualitative study exploring resident and faculty perspectives on what constitutes feedback culture, their perceptions of how institutional feedback culture (including politeness concepts) might influence the quality and impact of feedback, feedback seeking, receptivity, and readiness to engage in bidirectional feedback.

and allowed for the expression of a wide range of opinions.

Data analysis

We audiotaped and transcribed focus group discussions and interviews verbatim without inclusion of any names, and performed concurrent data collection and analysis using the constant comparative approach required for grounded theory research.[37,38,40–42] Trigger questions and probes were modified as needed for future discussions as relevant themes were identified. Data collection was stopped when we did not obtain significant additional themes related to our study questions and there was adequate information to construct a theoretical understanding.[47] Two investigators (S.R., E.E.P.) independently reviewed and coded the first three transcripts. These three transcripts were also coded by one of the other investigators (C.P.M.V., K.V.M., K.D.K.). By comparing and discussing their codes, the team reached consensus on a coding system for the rest of the dataset, which was analyzed and organized using NVivo 10 Pro software for Windows (QSR International Pty. Ltd., Melbourne, Australia) by S.R. and E.E.P. Field notes and investigator observations were coded using a similar strategy and contributed to the generation of themes; these interpretations were confirmed by member checking and backed by participant quotes. During first-level coding, each data unit referring to a specific issue was assigned an in vivo (using participants' words) code. During second-level coding, the number of codes was reduced by establishing coding categories which grouped codes by major subject areas. We then performed thematic analysis to identify major themes grounded in participant narratives rather than through a priori hypotheses.[48] Identified themes were discussed with the entire research team and influenced subsequent data collection through additional focus group discussion and interview questions. Once we coded the complete dataset, we moved from the categorical level (exploring opinions and beliefs) to the conceptual level (exploring relationships between categories and understanding meaning).[41,42] Ambiguities or disagreements in coding and generation of themes were resolved by consensus at research team meetings. Finally, we considered our analysis through the lens of politeness theory[26] and organizational culture,[22,23] exploring how our findings aligned with or challenged these constructs.

This study was granted exempt status by the Partners Institutional Review Board, the review board for Brigham and Women's Hospital (protocol no. 2013P002270/BWH). The board deemed that verbal consent was adequate provided that narratives were deidentified.

Results

Of those we invited, 29 residents and 22 general medicine faculty participated in focus group discussions, and 8 subspecialty faculty participated in interviews (Table 1).

We discovered three key themes situated within the broader cultural context: normalizing constructive feedback to promote a culture of growth, overcoming the mental block to feedback seeking, and hierarchical culture impeding bidirectional feedback. These themes as well as reported barriers and facilitators for each theme are depicted in Figure 1.

In the remainder of this section, we will first look at participants' definitions of feedback culture and perceptions of the institutional feedback culture at Brigham and Women's Hospital, and then we will discuss each of the three themes noted above.

Throughout this section, in the labels following each quote, R denotes resident comments (with the number following the R referring to the resident's PGY (e.g., PGY-2 resident = R2), and F denotes faculty comments.

Cultural context: The institutional feedback culture

Many participants defined a feedback culture as one that communicated clear institutional expectations promoting regular two-way feedback conversations. As further elaborated on below in the section on theme 3, both faculty and residents emphasized the bidirectional aspect in their definition of feedback culture.

Table 1

Participants (Residents and Faculty),[a] Internal Medicine Residency Program, Department of Medicine, Brigham and Women's Hospital, April–December 2016

Focus group/ individual interviews	Participants	No. of participants
Focus group	Residents	6 (2 PGY-1, 1 PGY-2, and 3 PGY-3)
Focus group	Residents	7 (2 PGY-1, 2 PGY-2, and 3 PGY-3)
Focus group	Residents	5 (1 PGY-1, 2 PGY-2, and 2 PGY-3)
Focus group	Residents	5 (2 PGY-1, 2 PGY-2, and 1 PGY-3)
Focus group	Residents	6 (2 PGY-1, 3 PGY-2, and 1 PGY-3)
Focus group	General medicine faculty (continuity clinic preceptors)[b]	4
Focus group	General medicine faculty (hospitalist attendings)[c]	10
Focus group	General medicine faculty (continuity clinic preceptors)[b]	8
Individual interviews	Subspecialist faculty (oncology)[d]	4
Individual interviews	Subspecialist faculty (cardiology)[d]	4

Abbreviation: PGY indicates postgraduate year.
[a]In a qualitative study exploring resident and faculty perspectives on what constitutes feedback culture, their perceptions of how institutional feedback culture (including politeness concepts) might influence the quality and impact of feedback, feedback seeking, receptivity, and readiness to engage in bidirectional feedback.
[b]General internists who served as resident continuity clinic preceptors; some also attended on general medicine wards for 2 to 4 weeks a year.
[c]Attending physicians who primarily worked on general medicine wards on the teaching service.
[d]Subspecialty attending physicians who worked on the inpatient subspecialty teaching service.

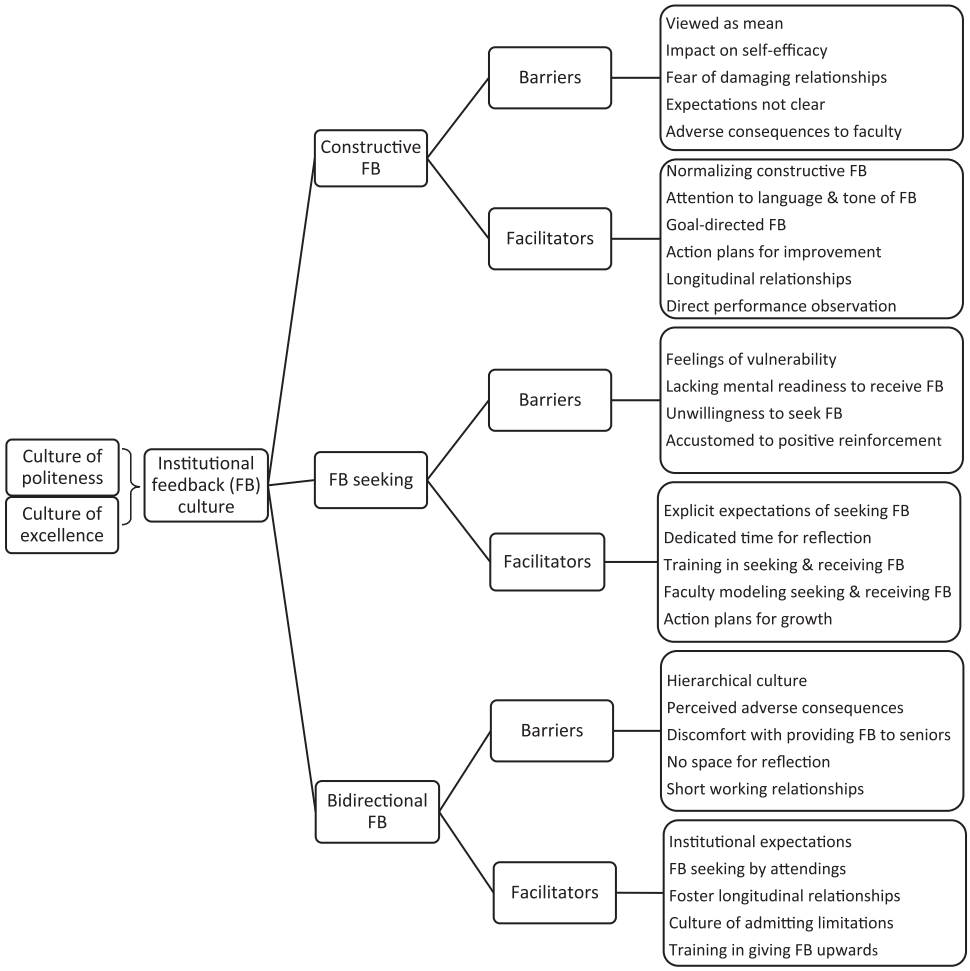

Figure 1 Flow diagram generated from focus group discussions and interviews with residents and faculty, internal medicine residency program, Department of Medicine, Brigham and Women's Hospital (April–December 2016), showing their perceptions of the impact of institutional feedback culture. Three themes were identified from the narrative data related to constructive feedback, feedback seeking, and bidirectional feedback. For each theme, participants listed facilitators and barriers that would enhance or impede the institutional feedback culture. This study explored resident and faculty perspectives on what constitutes feedback culture, their perceptions of how institutional feedback culture (including politeness concepts) might influence the quality and impact of feedback, feedback seeking, receptivity, and readiness to engage in bidirectional feedback.

> Feedback culture is a part of our existence here, to observe other people and give them feedback, but also to have people observe and give us feedback. I feel it's an expectation that it's a part of our daily life. (R2)

> It means … we have a culture where feedback is expected and accepted with open arms and where it just is normal to be providing feedback regularly. (F)

Culture of politeness. There was general agreement among most residents and faculty that the institution had a strong culture of politeness that implicitly discouraged feedback language that might be potentially threatening to residents' self-esteem. It was described by faculty as a "warm and fuzzy cocoon" for residents and by residents as a "family-like atmosphere."

> We do have a culture here of being like a family and support each other. People are hesitant to give any criticism. There's usually not a lot of specifics. (R1)

> We all sort of pat each other on the back, and don't have an open culture in terms of giving constructive criticism to each other. (R2)

> The concept is being able to give a range of feedback, positive and negative. But what a lot of this comes back to is, "Yes, yes, fine. You're doing great." Nobody gets things to work on. (F)

In contrast to the clinical teaching environment, a few faculty stated that it was less challenging to provide constructive feedback to research trainees. It was felt that because feedback to clinical trainees involves complex competencies, such as communication skills and professionalism, giving constructive feedback on these skills could be more threatening for these trainees and harder for them to accept than is feedback for research trainees.

> The culture is very supportive of the residents, but they almost never get corrected. I'm thinking about my research life, if someone presents something, people say, "That just doesn't work." It's a different environment. (F)

The tension between the desire to provide meaningful, constructive feedback and the fear of damaging interpersonal relationships was alluded to frequently.

> I struggle with trying to figure out how to deliver effective, constructive feedback without alienating interns, without overwhelming them. (R2)

> There is a culture of not wanting to hurt each other's feelings and being awkward in delivery. (F)

Culture of excellence. The culture was also described by residents and faculty as one where the institution's outstanding academic reputation and the pedigree of its trainees inhibited constructive feedback.

> Even though people here are amazing, we all have areas to improve on and weaknesses. The culture here may hinder the type and the quality of feedback that we give. (R3)

> It's tougher to give difficult feedback to someone who has, all their life, been treated with superlatives. It's a barrier to giving good feedback in this place. (F)

Faculty expressed concern about being taken to task if they provided constructive comments that could be threatening to residents' self-efficacy.

> It's a fabulous institution with fabulous residents at the top of the game, but sometimes, there are things not done correctly. If we tell them, what does that mean to the team dynamic … what [does] this [mean] for retaliation, which has happened to some faculty. There are cultural issues around everyone here being exceptional that are important to acknowledge. (F)

Faculty also alluded to the possibility that residents at prestigious institutions may suffer from an imposter complex and that "negative" comments could threaten their already fragile self-esteem.

> On the flip side is this imposter complex that everyone in this place has. It's not only that they base their self-esteem on excellence, but on the other side, they're like, I don't belong here. That also makes the whole thing higher stakes, I think. (F)

The "pedigree" of residents and unquestioned assumptions of their excellence were viewed by faculty as significant barriers to providing constructive feedback.

Theme 1: Normalizing constructive feedback to promote a culture of growth

Though the institutional feedback culture was noted to be a barrier to constructive feedback, both residents and faculty participants felt that it was important to have those conversations without negative connotations.

> If we strive for excellence, we should constantly be vigilant about the things we're better and worse at. Normalizing that we all have weaknesses and strengths is the most important part of making sure that constructive feedback happens and should happen from the top. (R3)

Short working relationships, common during residency training, were viewed as a major obstacle to constructive, goal-directed feedback conversations. Faculty also indicated that they felt a decreased sense of ownership for a resident's growth without a longitudinal relationship.

> How do I become better as a leader, how do I become better as a physician overall? I think having more longitudinal feedback would be helpful. We work with people for a week or two weeks. By the time you even learn how to work with them, you're on to the next thing and they don't get to see you grow over time. (R3)

> I've struggled with continuity. For ambulatory precepting to be effective in terms of feedback, you need a lot of data points. You need to be able to have—whatever the equivalent of [plan–do–study–act] cycles is. Give them something to work on, see how they're doing. (F)

The degree to which direct performance observation could contribute to meaningful feedback seemed to surprise many residents and faculty.

> When somebody watched me in clinic and gave feedback, I was just relieved. I had no idea if what I was doing in the room with patients was right, because no one had ever watched me. (R1)

> I never would've picked that up had I not actually been sitting there. I actually like this idea of the observation, because I think you're seeing something different than "you present well and you seem to be nice and everybody likes you." (F)

However, a few residents saw the presence of a faculty observer as intrusive and a potential threat to autonomy.

> Because you're so busy and it feels artificial when we have direct observation. It's an autonomy thing, and a fine balance. (R1)

Suggestions for promoting constructive feedback exchanges and an overall culture of growth included attention to language and tone of feedback, longitudinal relationships, direct performance observation without threatening autonomy, goal-directed feedback, action plans for improvement, and normalizing constructive feedback exchanges.

Theme 2: Overcoming the mental block to feedback seeking

Active feedback seeking was a relatively rare occurrence overall. PGY-1 residents were mentally unprepared to seek feedback, which they generally equated to criticism, because they were overwhelmed by hectic clinical commitments.

> Intern year is tough and you don't have the bandwidth to receive it. You're holding on for dear life, and it's like, "I'm just going to get through the day." (R1)

The more senior residents empathized with these sentiments as they too approached feedback conversations with some trepidation.

> You make yourself vulnerable. I now think about asking for feedback in a way I wouldn't have before, because I had a mental block. I didn't want to make myself vulnerable. (R3)

However, PGY-2 and PGY-3 residents also wished that they had been more proactive at seeking feedback during internship. Ironically, uncertainty regarding their skills and competence seemed to rise especially as they approached PGY-3 and were heading toward independent practice, and thus, they sought feedback more frequently to assess their strengths and areas in which they could improve.

> It shouldn't just be on the attendings. The best feedback I've gotten is when I've been proactive. I've tried to do more of that this year, asking my attendings after rounds and seeking out feedback more regularly. (R3)

Several faculty welcomed feedback seeking from residents as they felt it allowed them to provide specific feedback related to learning goals.

> We're not always focused on giving feedback or thinking about what each resident needs the feedback on. To be directed by the resident, I think is terrific. It doesn't happen much, but it's wonderful when it does. (F)

Residents indicated that direct performance observation and goal-directed feedback would enhance the credibility and acceptability of feedback.

> I really think they should be expected to observe us more. Because they have things they can draw on to form concrete opinions about how we take care of patients, how we think. Versus the overall, "Gosh, I liked you." (R2)

It was recommended that feedback training include strategies for seeking and receiving feedback, and framing feedback to enhance receptivity rather

than focusing solely on the techniques of providing feedback.

> Just teach people to seek out constructive criticism, so that they grow. (R3)

> A lot of us [faculty] don't know how to frame constructive feedback in a way that allows them [residents] to receive it well and [act on it]. I think that takes lots of time and experience to figure out how to be direct with somebody and have them thank you for it. (F)

PGY-1 residents seemed mentally unprepared to seek and receive constructive feedback. According to participants, this lack of cognitive and emotional space to engage in performance-related feedback could benefit from explicit institutional expectations, training in feedback seeking and receiving, dedicated time for reflection, faculty modeling seeking and receiving feedback, and opportunities to implement performance improvement plans.

Theme 3: Hierarchical culture impeding bidirectional feedback

Most residents stated that even the most nurturing clinical environment is fundamentally hierarchical, which impedes the provision of constructive feedback to upper levels.

> Just thinking as an intern, it's even hard to give feedback to your resident, let alone your attending. (R1)

> As much as we like to think that this is a nonhierarchical environment, it is hierarchical. Maybe less than other places, but it's a natural tendency of humans to want to be deferential to those who influence their trajectories in life. (R3)

There was a common perception among residents that attendings would not be receptive to constructive feedback or willing to change their behaviors.

> I think there are times where you decide it's not worth the effort. I'm only going to be with this person for five more days. Yeah, the way they do this one thing is annoying, but it's just going to be five days. Let me just go on to the next thing. (R3)

On those occasions when faculty sought feedback, residents still did not know how to approach the conversation.

> I've been asked for feedback and not really given it to an attending. I don't know how to give feedback to a superior. That's an unfortunate part of the culture. (R2)

> Someone asked me, "Well, what could I do better?" My mind went blank. I'm like, "I don't really think about you in that way. You're my superior and I accommodate my daily routine to meet your activity." (R2)

There were many residents in favor of promoting a culture of bidirectional feedback provided that faculty initiated the dialogue.

> Having that attending say to me, "Hey, I would really appreciate more feedback. Why don't we sit down tomorrow?" I think that breaks that "personality" or "relationship" barrier. (R3)

The personality of attending physicians and the manner of their team interactions were believed to influence bidirectional feedback. Residents also stated that knowing institutional teaching expectations could help them to provide more specific feedback to their faculty.

> I feel that the personality of an attending who can create a more lighthearted atmosphere makes giving feedback a little bit easier. (R2)

> Maybe making expectations of attendings more transparent … then we can give more accurate feedback. "Well, you were supposed to be here to do this, this, and that, and I don't feel we're getting that from you." (R3)

Faculty, on the other hand, stated that even when they sought feedback, they did not get honest or specific comments.

> People giving feedback to their supervisors is always a little dicey. You don't actually get their honest opinion. (F)

> I get mostly suggestions about conferences, topics, and things even when I asked. I don't get any constructive criticism on my teaching. (F)

Faculty seemed willing to engage more in seeking feedback from residents. One faculty participant stated that admitting his own limitations tended to break down hierarchical barriers and allow residents to provide feedback:

> It sets up this culture of bidirectional feedback. "I'm going to give you feedback. You're going to give me feedback. This is how we do things. This is how we get better. I can always get better. I've been doing this for 15 years, and I can still get better." If you send that message, I think it makes it that much easier to get feedback. (F)

There were varying degrees of openness to bidirectional feedback despite its inclusion in the definition of a feedback culture by residents and faculty. However, overall residents were willing to engage provided that faculty actively sought feedback and there was an institutional feedback culture that encouraged and promoted feedback up the hierarchy.

Discussion

In this study, we sought to explore resident and faculty perspectives regarding what constitutes feedback culture, their perceptions of how institutional feedback culture (including politeness concepts) might influence the quality and impact of feedback, feedback seeking, receptivity, and readiness to engage in bidirectional feedback. In doing so, we hoped to learn more about the areas of congruence and incongruence in the two groups' mental models of the feedback culture that could be helpful in designing culture-enhancing initiatives.

Several faculty and resident participants used the terms "culture of excellence" and "culture of politeness." The culture of excellence refers to the outstanding academic reputation of the institution and pedigree of its trainees, which can inhibit constructive feedback. The culture of politeness refers to the collegial and supportive work environment that could prevent the use of language that has the potential to adversely affect self-esteem. As depicted in Figure 1, these two facets of the cultural context act as the starting point for the three key themes we found (see above); Figure 1 also shows participant descriptions of facilitators and barriers pertaining to each category of the feedback culture. Using these descriptions and themes, we developed the framework shown in Figure 2, based on varying degrees of resident and faculty openness to constructive feedback exchanges, feedback seeking, and bidirectional feedback (see the figure legend for an explanation of the axes and quadrants).

In our framework, the bottom left quadrant, where faculty and residents hesitate to engage in feedback seeking, constructive feedback exchanges, and bidirectional feedback, is titled the "culture of assumed excellence." In this type of culture, the institutional reputation for academic and clinical excellence appears to lead to assumptions

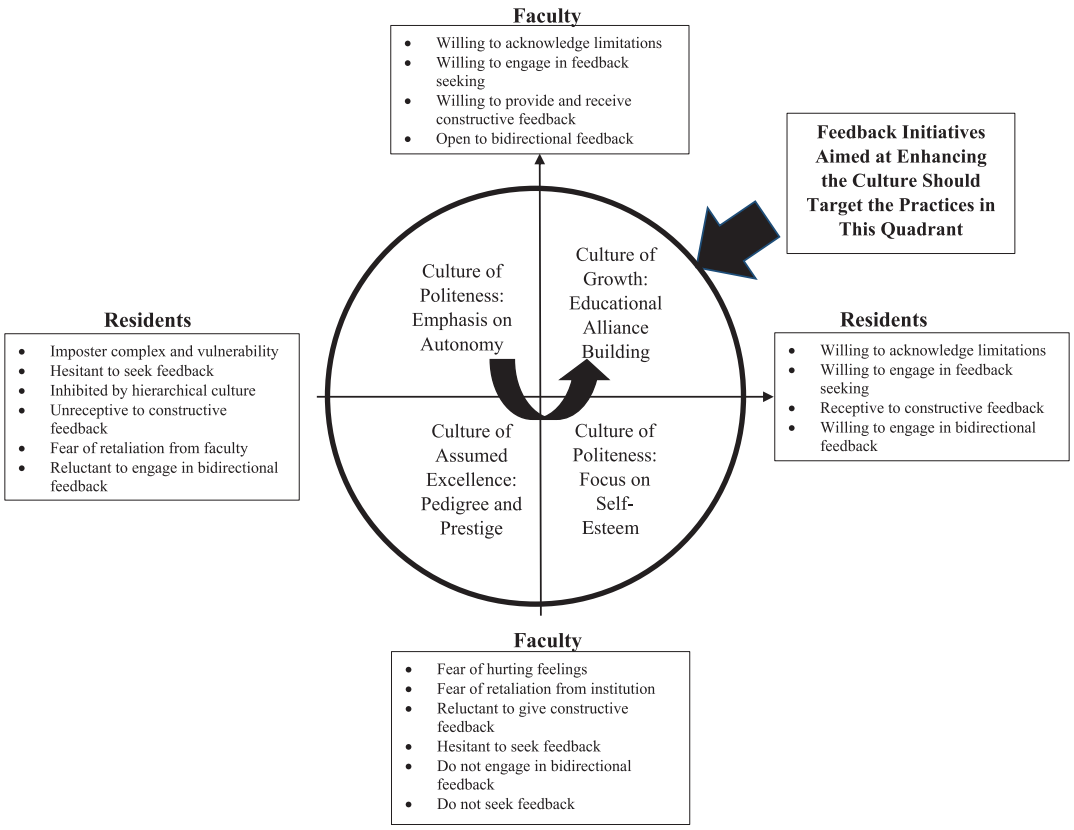

Figure 2 Model developed from the narratives of residents and faculty, internal medicine residency program, Department of Medicine, Brigham and Women's Hospital, regarding what constitutes feedback culture, how institutional feedback culture (including politeness concepts) might influence the quality and impact of feedback, feedback seeking, receptivity, and readiness to engage in bidirectional feedback, April–December 2016. Resident feedback practices are represented along the x-axis, and faculty feedback practices are represented along the y-axis. The intersection of these axes results in four quadrants, each denoting a certain cultural climate for feedback: (1) culture of politeness: emphasis on autonomy; (2) culture of excellence: pedigree and prestige; (3) culture of politeness: focus on self-esteem; and (4) culture of growth: educational alliance building. Each of these quadrants is linked to aspects of politeness theory and components of organizational culture.[22,26,27] All the terms and labels used in the figure reflect words that were used by the participants. The circular arrow indicates that feedback culture should ideally move toward a culture of growth.

that everyone is outstanding and that "negative" statements are not permitted in feedback conversations. A lack of longitudinal relationships and a hierarchical institutional culture would also be barriers to honest and meaningful dialogue in such a culture.[4,9,49] Further, a fear of retaliation would inhibit feedback from residents to faculty, and an underlying lack of self-confidence or the imposter complex could underlie the lack of feedback seeking and receptivity. These factors are important to explore and address to promote an open feedback culture.

The bottom right quadrant can be characterized by residents' openness to feedback seeking and bidirectional feedback but faculty reluctance to engage in constructive and bidirectional feedback. This combination could promote nonspecific conversations with a focus on preserving positive face or self-esteem. Preserving positive face, the desire to be approved by others, and how it shapes language use in feedback interactions are very relevant to the findings of this study.[26,27] Other investigators have also reported the fear of hurting feedback receivers' feelings and damaging working relationships as major barriers to the exchange of constructive feedback, which would apply in this type of culture.[4,10,50] Interestingly, in our study, some faculty stated that providing feedback perceived as threatening to residents' self-esteem had led to admonishment from departmental leadership; this fear of retaliation would impede the provision of honest, constructive feedback.

The top left quadrant is characterized by faculty openness to engage in feedback seeking and bidirectional feedback but residents' reluctance to seek and receive constructive feedback. A hierarchical learning culture, real or perceived, and a lack of cognitive and emotional space to receive constructive feedback would also impede feedback seeking and receptivity in this type of culture. If residents are perceived as not receptive, faculty might initiate conversations that avoid any threat to resident autonomy—that is, negative face.[26] Watling[51] and Watling and colleagues[4] reported that the emphasis on autonomy and independent practice in medical education often prevents direct observation of performance by faculty and acts as a barrier to an open feedback culture. If feedback providers encode their messages using polite language aimed at preserving self-esteem or autonomy, the feedback receiver may decode and construct a meaning that contradicts the original message.[28] The hedging and hidden code described by Ginsburg and colleagues[29,30] are very applicable to in-person feedback conversations in such a culture.

We titled the top right quadrant the "culture of growth," a term used by one

resident participant, to indicate openness to feedback seeking and bidirectional feedback on both sides. These behaviors set the tone for educational alliance building, which stimulates discussion and exchange of professional goals, goal-directed feedback, and action plans for improvement.[52] For this culture to work, both faculty and residents need to make themselves vulnerable and open to discussion of their weaknesses so that they can embrace professional growth.

Applying Schein's[22] levels of culture to resident and faculty perceptions of the existing feedback culture, underlying assumptions may involve politeness and institutional pride in its reputation (level 1), and espoused values may be the written expectations of regular feedback and professional growth (level 2); however, the more visible day-to-day behaviors may be dominated by the desire to preserve face (level 3). This concept is reflected in a faculty participant comment, "the value and need for feedback is communicated but there is a gap in translating the intent to action." Without addressing the mismatch between the three levels of culture,[22] change strategies may not be successful.

Limitations and strengths

This study has limitations which may have affected our findings. It was conducted in a single department at a single academic health center. Thus, these resident and faculty perceptions may not be completely transferable to other departments or institutions. Though focus group discussions and interviews explore participants' stated perceptions, these may differ greatly from their actions and behaviors. Despite a large quantity of narrative data, we may not have captured a full range of opinions. Nonparticipants could have strong and contradictory feelings about feedback and the institutional feedback culture which we may have missed. Moreover, the more junior residents may not have shared their opinions openly in a mixed focus group where senior residents were also present. Institutional feedback culture is likely to be different at different institutions and in different departments; thus, these results may not be applicable without further explorations of the specific cultural context. Further, learning cultures in departments such as surgery and anesthesiology would be markedly different from internal medicine. For example, in surgery, a key learning setting is the operating room where the culture is more hierarchical, contact between supervisors and trainees is limited to the duration of the procedure, and the focus would be on specific skills-based feedback that would likely mostly be constructive.[53,54] Though surgical trainees engage in feedback seeking and are receptive to feedback from supportive supervisors, the complexities of relationship building in these settings would be entirely different than continuity clinics or even inpatient rotations, and politeness concepts may not be applicable.[55]

We have tried to enhance the credibility of the findings by using multiple data sources to triangulate the findings and independent data analysis by two or more investigators to ensure that the discovered themes were not guided by a single investigator's assumptions or biases. The findings appear to resonate with existing feedback literature describing sociocultural factors that influence feedback.[4,10,11,15,16,18,51] Our context is typical of large, urban medicine residency programs situated within major academic medical centers; therefore, many of the findings may be relevant and applicable to similar educational settings. Finally, attention was paid to reflexivity in formulating study questions, data collection, and data analysis.

Suggestions for further research

In this study, we explored the perceptions of residents and faculty regarding the influence of the institutional feedback culture on the quality and impact of feedback conversations. It is also important to observe real-time feedback conversations to examine whether the verbal and nonverbal behaviors used by faculty and residents are congruent with expressed opinions, challenges, and intentions. Such observations would benefit from an ethnographic approach where feedback conversations can be debriefed through reflection and reflexivity. It will also help us to understand the existing levels of institutional feedback culture and facilitate the design of robust initiatives that target a cultural shift in feedback practices at the institution, yet preserve the supportive work and learning environment. Even if feedback initiatives actively promote feedback-seeking behaviors, normalize constructive feedback exchanges, empower junior learners to give feedback to senior levels, and encourage acknowledgment of limitations at all levels, junior trainees still may not distinguish between summative feedback during assessment and formative feedback aimed at professional development. Thus, they may avoid giving formative feedback to faculty for fear of ruining future fellowship or career prospects in competitive work settings. Additionally, further research could explore resilience training for both residents and faculty, the potential use of narrative data in enhancing feedback cultures, and differences between feedback in clinical and research settings. Finally, assessments of organizational cultures may be useful to determine whether change management initiatives are successful.[56]

Conclusions

An institutional feedback culture of excellence and politeness may impede honest and meaningful feedback and may influence feedback seeking, receptivity, and bidirectional feedback exchanges. Understanding the assumptions and values that constitute an institutional feedback culture and recognizing the barriers to change, as well as aligning proposed new initiatives with the existing mission and showcasing their benefits, are essential to guide successful culture change.

Dedication: The late Dr. Karen V. Mann was a major source of inspiration and guidance to the research team and a personal role model to S. Ramani. She was instrumental in guiding each step of this research project, including the literature review, study design, data analysis, and initial manuscript writing. Her mentoring, compassion, wisdom, patience, and guidance will be sorely missed. It was a privilege for the authors to have worked with her. This is a tragic loss to the world of medical education.

Acknowledgments: The authors gratefully acknowledge the residents and faculty who enthusiastically participated in the study and shared their perceptions, challenges, and suggestions for best practices related to feedback, as well as the leadership of the Department of Medicine at Brigham and Women's Hospital for their active support of educational research in general and this research in particular. The authors would also like to acknowledge Dr. Shiphra Ginsburg for her thoughtful review and feedback on the manuscript.

Funding/Support: This study was funded by the Department of Medicine Clinical Education

Research Scholars Grant at Brigham and Women's Hospital.

Other disclosures: None reported.

Ethical approval: The study was granted exempt status by the Partners Institutional Review Board, the review board for Brigham and Women's Hospital (protocol no. 2013P002270/BWH). The board deemed that verbal consent was adequate provided that narratives were deidentified.

Previous presentations: This research study was presented as a short communication at the 2017 Annual AMEE (Association of Medical Education in Europe) Meeting, Helsinki, Finland, August 28, 2017.

S. Ramani is director, Scholars in Medical Education Pathway, Internal Medicine Residency Program, Brigham and Women's Hospital, and assistant professor of medicine, Harvard Medical School, Boston, Massachusetts; ORCID: http://orcid.org/0000-0002-8360-4031.

K.D. Könings is associate professor, School of Health Professions Education, Maastricht University, Maastricht, the Netherlands; ORCID: http://orcid.org/0000-0003-0063-8218.

K.V. Mann was professor emeritus, Division of Medical Education, Faculty of Medicine, Dalhousie University, Halifax, Nova Scotia, Canada.

E.E. Pisarski is research associate, Global Health and Social Medicine, Harvard Medical School, Boston, Massachusetts.

C.P.M. van der Vleuten is director, School of Health Professions Education, and professor of education, Department of Educational Development and Research, Faculty of Health, Medicine and Life Sciences, Maastricht University, Maastricht, the Netherlands; ORCID: http://orcid.org/0000-0001-6802-3119.

References

1 van de Ridder JM, Stokking KM, McGaghie WC, ten Cate OT. What is feedback in clinical education? Med Educ. 2008;42:189–197.
2 Boud D. Feedback: Ensuring that it leads to enhanced learning. Clin Teach. 2015;12:3–7.
3 Delva D, Sargeant J, MacLeod T. Feedback: A perennial problem. Med Teach. 2011;33:861–862.
4 Watling C, Driessen E, van der Vleuten CP, Vanstone M, Lingard L. Beyond individualism: Professional culture and its influence on feedback. Med Educ. 2013;47:585–594.
5 Ramani S. Reflections on feedback: Closing the loop. Med Teach. 2016;38:206–207.
6 Molloy E, Boud D. Seeking a different angle on feedback in clinical education: The learner as seeker, judge and user of performance information. Med Educ. 2013;47:227–229.
7 Parkes J, Abercrombie S, McCarty T. Feedback sandwiches affect perceptions but not performance. Adv Health Sci Educ Theory Pract. 2013;18:397–407.
8 Watling C. Cognition, culture, and credibility: Deconstructing feedback in medical education. Perspect Med Educ. 2014;3:124–128.
9 Watling C, Driessen E, van der Vleuten CP, Lingard L. Learning culture and feedback: An international study of medical athletes and musicians. Med Educ. 2014;48:713–723.
10 Sargeant J, McNaughton E, Mercer S, Murphy D, Sullivan P, Bruce DA. Providing feedback: Exploring a model (emotion, content, outcomes) for facilitating multisource feedback. Med Teach. 2011;33:744–749.
11 Mann K, van der Vleuten C, Eva K, et al. Tensions in informed self-assessment: How the desire for feedback and reticence to collect and use it can conflict. Acad Med. 2011;86:1120–1127.
12 Sargeant J, Armson H, Chesluk B, et al. The processes and dimensions of informed self-assessment: A conceptual model. Acad Med. 2010;85:1212–1220.
13 Sargeant J, Eva KW, Armson H, et al. Features of assessment learners use to make informed self-assessments of clinical performance. Med Educ. 2011;45:636–647.
14 Sargeant J, Mann K, Sinclair D, van der Vleuten C, Metsemakers J. Challenges in multisource feedback: Intended and unintended outcomes. Med Educ. 2007;41:583–591.
15 Sargeant JM, Mann KV, van der Vleuten CP, Metsemakers JF. Reflection: A link between receiving and using assessment feedback. Adv Health Sci Educ Theory Pract. 2009;14:399–410.
16 van de Ridder JM, Berk FC, Stokking KM, Ten Cate OT. Feedback providers' credibility impacts students' satisfaction with feedback and delayed performance. Med Teach. 2015;37:767–774.
17 Harrison CJ, Könings KD, Schuwirth L, Wass V, van der Vleuten C. Barriers to the uptake and use of feedback in the context of summative assessment. Adv Health Sci Educ Theory Pract. 2015;20:229–245.
18 Eva KW, Armson H, Holmboe E, et al. Factors influencing responsiveness to feedback: On the interplay between fear, confidence, and reasoning processes. Adv Health Sci Educ Theory Pract. 2012;17:15–26.
19 Watling C, Driessen E, van der Vleuten CP, Vanstone M, Lingard L. Music lessons: Revealing medicine's learning culture through a comparison with that of music. Med Educ. 2013;47:842–850.
20 Watling C. When I say … learning culture. Med Educ. 2015;49:556–557.
21 Ramani S, Post SE, Könings K, Mann K, Katz JT, van der Vleuten C. "It's just not the culture": A qualitative study exploring residents' perceptions of the impact of institutional culture on feedback. Teach Learn Med. 2017;29:153–161.
22 Schein EH. Organizational Culture and Leadership. 4th ed. San Francisco, CA: Jossey-Bass; 2010.
23 Kotter JP. Leading Change. Boston, MA: Harvard Business Review Press; 2012.
24 Hatch MJ, Schultz M. Relations between organizational culture, identity and image. Eur J Marketing. 1997;31:356–365.
25 Chou CL, Masters DE, Chang A, Kruidering M, Hauer KE. Effects of longitudinal small-group learning on delivery and receipt of communication skills feedback. Med Educ. 2013;47:1073–1079.
26 Goffman E. On face-work; an analysis of ritual elements in social interaction. Psychiatry. 1955;18:213–231.
27 Brown P, Levinson SC. Politeness: Some Universals in Language Usage. Cambridge, UK: Cambridge University Press; 1987.
28 Arundale RB. An alternative model and ideology of communication for an alternative to politeness theory. Pragmatics. 1999;9:119–153.
29 Ginsburg S, Regehr G, Lingard L, Eva KW. Reading between the lines: Faculty interpretations of narrative evaluation comments. Med Educ. 2015;49:296–306.
30 Ginsburg S, van der Vleuten C, Eva KW, Lingard L. Hedging to save face: A linguistic analysis of written comments on in-training evaluation reports. Adv Health Sci Educ Theory Pract. 2016;21:175–188.
31 Kiefer CS, Colletti JE, Bellolio MF, et al. The "good" dean's letter. Acad Med. 2010;85:1705–1708.
32 van de Ridder JM, Peters CM, Stokking KM, de Ru JA, Ten Cate OT. Framing of feedback impacts student's satisfaction, self-efficacy and performance. Adv Health Sci Educ Theory Pract. 2015;20:803–816.
33 Cameron KS, Quinn RE. Diagnosing and Changing Organizational Culture: Based on the Competing Values Framework. 3rd ed. San Francisco, CA: Jossey-Bass; 2011.
34 van de Ridder JM, McGaghie WC, Stokking KM, ten Cate OT. Variables that affect the process and outcome of feedback, relevant for medical training: A meta-review. Med Educ. 2015;49:658–673.
35 Crommelinck M, Anseel F. Understanding and encouraging feedback-seeking behaviour: A literature review. Med Educ. 2013;47:232–241.
36 Teunissen PW, Bok HG. Believing is seeing: How people's beliefs influence goals, emotions and behaviour. Med Educ. 2013;47:1064–1072.
37 Patton MQ. Qualitative Research and Evaluation Methods. 3rd ed. Thousand Oaks, CA: Sage; 2002.
38 Creswell JW. Educational Research: Planning, Conducting, and Evaluating Quantitative and Qualitative Research. 4th ed. Boston, MA: Pearson; 2012.
39 Ramani S, Mann K. Introducing medical educators to qualitative study design: Twelve tips from inception to completion. Med Teach. 2016;38:456–463.
40 Charmaz K. Constructing Grounded Theory. 2nd ed. London, UK: Sage; 2014.
41 Kennedy TJ, Lingard LA. Making sense of grounded theory in medical education. Med Educ. 2006;40:101–108.
42 Watling CJ, Lingard L. Grounded theory in medical education research: AMEE guide no. 70. Med Teach. 2012;34:850–861.
43 Krueger RA, Casey MA. Focus Groups: A Practical Guide for Applied Research. 5th ed. Thousand Oaks, CA: Sage; 2015.
44 Stalmeijer RE, Mcnaughton N, Van Mook WN. Using focus groups in medical education research: AMEE guide no. 91. Med Teach. 2014;36:923–939.
45 Kitzinger J. Qualitative research. Introducing focus groups. BMJ. 1995;311:299–302.
46 Watt D. On becoming a qualitative researcher: The value of reflexivity. Qual Rep. 2007;12:82–101.
47 Morse JM. "Data were saturated…." Qual Health Res. 2015;25:587–588.

48 Morse JM. Analytic strategies and sample size. Qual Health Res. 2015;25:1317–1318.

49 Bok HG, Teunissen PW, Spruijt A, et al. Clarifying students' feedback-seeking behaviour in clinical clerkships. Med Educ. 2013;47:282–291.

50 Sargeant J, Mann K, Sinclair D, Van der Vleuten C, Metsemakers J. Understanding the influence of emotions and reflection upon multi-source feedback acceptance and use. Adv Health Sci Educ Theory Pract. 2008;13:275–288.

51 Watling CJ. Unfulfilled promise, untapped potential: Feedback at the crossroads. Med Teach. 2014;36:692–697.

52 Telio S, Ajjawi R, Regehr G. The "educational alliance" as a framework for reconceptualizing feedback in medical education. Acad Med. 2015;90:609–614.

53 Jensen AR, Wright AS, Kim S, Horvath KD, Calhoun KE. Educational feedback in the operating room: A gap between resident and faculty perceptions. Am J Surg. 2012;204:248–255.

54 Ahmed M, Arora S, Russ S, Darzi A, Vincent C, Sevdalis N. Operation debrief: A SHARP improvement in performance feedback in the operating room. Ann Surg. 2013;258:958–963.

55 Gaunt A, Patel A, Rusius V, Royle TJ, Markham DH, Pawlikowska T. "Playing the game": How do surgical trainees seek feedback using workplace-based assessment? Med Educ. 2017;51:953–962.

56 Rougas S, Clyne B, Cianciolo AT, Chan TM, Sherbino J, Yarris LM. An extended validity argument for assessing feedback culture. Teach Learn Med. 2015;27:355–358.